Exhibit 19

EMG Study											
Name:		Ins Act.	Fibs	'PSW	Fascics	Polyph	MŲ Amp	MU Dur	Config	Pattern:	Recruit
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R. Biceas Brachl.		0000	none	none	none	погт	ល្ងាកា	nom	попп	norm	
	nom	8000	none	NOTE	none	nom	nom	nom	nom	LIOTIA.	
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R. Pronator Ter.		none	100uB	none	none	nom	nom	nom	попп	nom	
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R. Abd.Pol:Br.	nom nom	none	none	none	none	nom	norm	nom	norm	nom	
R. Dors.Int.1	nom	ugue,	none	none	none	nom	norm	попп	nom	nom	
	DOUBL	none	none	none	none	nom	norm	nom	norm	nom	
R. Cer Pare C6	nom	rione	none	none.	none	nom	norm	nom	nom	uoum.	
R. Cer Para C7	norm	úcus	LOUÉ	none	none	UÖM	nom	попп	nom	nom	
R. Cer Para T1	norm	none	nové	กอกอ	none	nom	nom	HOITE	norm norm	LIQUITY LIQUITY	
R. Co. Para C4	norm	uoue	none	none	none none	nom	nom nom	rionn nom	nom	nom	
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L. Triceps bracks.	SACRETORN	none		none	none	nom	nom	nem	nom	SOME	
L. Ext.Car.R.i.r.	DOM	none	enon	none	none	nom	NOTE	PORTI	nam	nom	
L. Pronator-Ter.	noan	none	none	none	none	norm	TION	NOTE	norm	nomi	
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L'Cer Para C4	riomii	none	none	none	none	nom	nom	nom	norm	LICHT	
L. Brachioradiale	s nonn	none	none	nane	none	neara	DOM	nom	nom	nom	
R. Vastus Med.	nom	попе	none	none	none	nom	nom	MOTE TO	nom nom	mon	
R, Tibials Ant.	ຄ່ວກາ	none	none	nona	nána	uouu.	nom	norm	nom	nom	
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R. Gastro Med R. Biceps Fern	nom	nome nome	лоле поле	none	Doue.	nom	nom	nonn	nom	nam	
R. Tensor Fas LI		none	none	Rone	uone	acon	nonn	norm	nom	nom	
A. Gastroc.Ln.H.		none	กอกอ	none	none	nom	norm	norm	nom	nom	
R. Lum Pára L2		none	กоле	none	none	norm	norm	nam	nom	BOLL	
R. Lum Para L3	nomi	none	none	none	none	mon	nann	nom	norm	norm	
R. Lom Para L4		กงกง	none.	none	лопф	nom	·norm	nonn	norm	UOUU	
R. Lum Para L5		none.	none	none	none	nom	nem	norm	norm	unour monu	
R, Lum Para \$1		none	-none	none	4000 4000	mon	nom	поло	nom	nom	
R. Lum Para \$2		none	none.	angn angn	none	nonn	חוועת	חתומת	norm	nam	
R. Peroneus Ln R. Vastus Let.	nom	nona nona	uova úoua	RONG	поле	nonn	nom	norm	ווסווו	nom	
R. Guteus Med.	*********	none	none	enon	nore	nom	nom	กดกา	norm	nom	
R. Med Ham	nom	none	none	none	none	ROM	nom	norm	norm	NOTES	
R. Lai Ham	nomi	'none	none	none	none	nom	norm	'noma	norm	notm	
L. Vastus Med.	nom	none	, none	none	none	nom	HDAN	nom	nom	nomi	
L. Tibielis Anl.	Normal	Inc	1+	none	none enon	inc norm	POPTE POPTE	nom	nom	nom	mom

	[. 1									page 4
Patient:	1 _{Kea}	acted) 			Test D	ate:	02/13/1	2			-
L. Gastro Mod L. Biceps Fern L. Tensor Fas Lt	Normal norm norm	inë none none	1+ none none	none none	none none	inc . nom nom	nom nom	norm ·	nonn nonn	nom nom	nom	
L. Gastroc.Ln.H. L. Lum Para L2 L. Lum Para L3	Noma nom nom	none none	t+ none none	uoue uoue uoue	none none	inc nom nom	norm norm	agan agan agan	norm norm	nom monn nom	полт	
L. Lum Para L6 L. Lum Para L6 L. Lum Para S1	Normal Normal norm	inc Inc none	1+ 1.+	none none	none none none	inc inc nom	nom nom	norm norm	HOMB HOMB	nom nom nom	HOTTA HOTTA	
L.,Lum.Para 52 L. Peroneus Ln L. Vastus Let	učius uceni uceni	none none	none none	ucue ucue ucue	tione Libra Libra Libra	nom nom nom	nom mon	norm moon	nom nom	nom nom		
L. Glideus Med. L. Med Ham L. Let Ham	nom nom nom	none none	none none none	COUG COUG	9000 9000 9000	norm norm	ucuu ucuu	NOUN NOUN	UOLU UOLU UOLU	nom nom		
L. Deficid L. Bicaps Fem Summary/1:	'nom nom hteriore	none none	none Figne	none	000e	norm norm	HORTH	norm	norm norm	nom		

- ABNORMAL EMG STUDY
- 2. ELECTRODIAGNOSTIC EVIDENCE (EDX) OF LEFT CERVICAL RADICULOPATHY MOST CONSISTENT WITH C5-6 LEVELS
- 3. NO EDX OF RIGHT CERVICAL RADICULPATHY
- 4. NO EDX OF BILATERAL RADIAL NEUROPATHY
- 5. NO EDX OF BILATERAL ULNAR NEUROPATHY
- 6. NO EDX OF BILATERAL CARPAL TUNNEL SYNDROME
- 7. NO EDX OF BILATERAL BRACHIAL PLEXOPATHY
- 8. PATIENT WILL FOLLOW UP IN 2-3 WEEKS

THOMAS CARUSO, D.O. JEFF S. PIERCE, D.O.

- 1. ABNORMAL EMG STUDY
- 2. ELECTRODIAGNOSTIC EVIDENCE (EDX) SUGGESTIVE OF LEFT LUMBOSACRAL RADICULOPATHY MOST CONSISTENT WITH L4-5 LEVELS
- 3. NO EDX OF RIGHT LUMBOSACRAL RADICULOPATHY
- 4. NO EDX OF BILATERAL PERONEAL NEUROPATHY
- 5. NO EDX OF BILATERAL SURAL NEUROPATHY

			page 5
Patient: Redacted	Test Date:	02/13/12	

6. PATIENT WILL FOLLOW UP IN 2-3 WEEKS

THOMAS CARUSO, D.O. JEFF S. PIERÇE, D.O. 1500

STATE FARM INSURANCE P.O. BOX 661023

HEALTH INSURANCE CLAIM F		. /5266
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE	: 08/05	PICA TTT
	CHAMPVA GROUP FECA OTHER	1 ta. INSURED'S I.D. NUMBER (For Program In Item 1)
1. MEDICARE MEDICAID TRICAHE CHAMPUS (Medicare #) (Medicard #) (Sponsor's SSN)	CHAMPVA GROUP FECA OTHER HEALTH PLAN BLK LUNG (SSN) X(ID) (SSN) X(ID)	22054X249
2. PATIENT'S NAME (Last Name, First Name, Middle Initial		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Redacted	Redacted FX	Redacted J
It It I I I I I I I I I I I I I I I I I	6. PATIENT RELATIONSHIP TO INSURED	T7
	Self X Spouse Child Other	
	8. PATIENT STATUS	
	Single Married Other 🔀	H
4	Full-Time Part-Time	
	Employed Student Student	11. INSURED'S POLICY GROUP OR FECA NUMBER
9. OTHER INSOREO'S NAME (LEST NAME, TYST NAME, WA	10. IS PATIENT'S CONDITION RELATED TO:	TI. INSURED S FOCIOT GREET STATE CONTINUES.
The second secon	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S POLICY GROUP OR FECA NUMBER B. INSURED'S DATE OF BIRTH Redacted NAME NAME
B. OTHER INSURED'S POLICY OR GROUP NUMBER	YES X NO	Redacted MD FX
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMP NAME
L MM L DO L YY	F XYES NO MI	
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	STATE FARM INSURANCE
d INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
		YES X NO # yes, return to and complete item 9 a-d.
	RE COMPLETING & SKINING THIS FORM. El authoriza the release of any medical or other information necessary	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for
to process this claim. I also request payment of govern	ment benefits either to myself or to the party who accepts assignment	services described below.
SIGNATURE ON FILE	02 27 12	SIGNED SIGNATURE ON FILE
SIGNED	DATE	
14. DATE OF CURRENT: ILLNESS (First symptom) MM DD YY INJURY (Accident) DR PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY	FROM DD YY MM DD YY
		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
17. NAME OF REFERRING PROVIDER OR OTHER SOUL THOMAS CARUSO DO 19. RESERVED FOR LOCAL USE	17b, NPI 1144333972	FROM DD YY MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
		YES X NO 000
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.	(Relate Items 1,2,3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CRIGINAL REF. NO.
722.0	3 . <u>1</u> 723. <u>4</u>	
,		23. PRIOR AUTHORIZATION NUMBER
2 722 10	4 724 4	F. G. H. I. J.
24. A. DATE(S) OF SERVICE B. From to PLACE OF	(Explain Unusual Circumstances) DIAGNOSIS	BAYS EPSOT ID. RENDERING
MM DD YY MM DD YY SERVICE E	MG CPTHCPCS L MODIFIER POINTER	\$ CHARGES UNITS PROVIDER ID. #
02:13:12 02:13 12 11	95886	2400 00 4 NPI 1144333972
02 120 122 102 13 122 111	1 3 3 3 4 1 1 1 1 2 3 4	1 2 2 3 3 1 2 1 2 2 3 3 3 3 3 3 3 3 3 3
02 13 12 02 13 12 111	195904 1234	2560 00 8 NPI 1144333972
02 13 12 02 13 12 111	95900 59 1234	1980 00 6 NPI 1144333972
02 13 12 02 13 12 111	95903 59 1234	1830 00 6 NPI 114433397.2
		, , , ,
02 13 12 02 13 12 11	95934 59 RT 1234	385 00 1 NP 1144333972
0 02! 13!12 102!13 12 1111	locace leaders! ! leade	1 385 nn l1 NPI 1144333972
02 13 12 02 13 12 11	95934 59 LT 1234	385 00 1 NP 1144333972 28. TOTAL CHARGE 29 AMOUNT PAID 30. BALANCE DUE
25. FEDERAL TAX I.D. NUMBER SSN EIN	28. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For gov1. claims, see back) 40360C31315 X yes No	\$ 9540 00 \$ 0 00 \$ 9540 00
31. SIGNATURE OF PHYSICIAN OF SUPPLIER	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (248)8894580
INCLUDING DEGREES OR CREDENTIALS (I carify that the statements on the reverse	MICHIGAN SPINE & REHAB DT	MICHIGAN SPINE AND REHAB
apply to this bill and are made a part thereof.)	23861 MCNICHOLS	2000 TOWN CENTER SUITE 625
THOMAS CARUSO DO	DETROIT MI 48219-3124	SOUTHFIELD MI 48075-1135
02 28 12 SIGNED DATE	1518027606 b.	a.1518027606 b.
NUCC Instruction Manual available at: www.		APPROVED OMB 0938-0999 FORM CMS-1500 (08/05
MINEY INSTRUCTION MINIMUM DAGRETING OF ASSAULT		

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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, consurance and noncovered services. Consurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (WEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service. 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims. I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the <u>Federal Rogister</u>, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for med cal care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party kability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claims will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OWB control number. The valid OWB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer. 7500 Security Boulevard, Baltimord, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT WAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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Patient:	Ikea	acte	a				C	11/11/12	۱۸.	1200	1	Ó-10-
S.S. No.									MIN	111-6	(02)	P790
F-Wave Stu	dy											
Right Median-Uir	er Nervo		Letency	•								
Rec Site: Stim Site:			UNS .									
M wave			2.67 29.50									
wava M			28.83									
EMG Study	.											
Name						Rep	₩¢amp	МСатр	MU dur	Phasics	Rec Pat	TEXT
R. Deltold	Normal	(m)Q/F	none	none	nons	none	וונוסוו	nom	nonni	ACTO ACTO	full full	
R. Triceps R. Ext.Car.R.L	Normal Normal	nom) nom	none cone	enon enon	none	none none	renn renn	nomi nomi	nonn	(NOTE)	futi	
R, Biceps Breo	Normal	ENOTE	none	none	HOTHE	hone	nom	nom	nom	110/11)	full	
R. Extind.Pro R. Pronator Te	Normal Normal	nom nom	none sone	NOTE:	none none	none enon	DOM:	nonn nom	nonn nonn	स ा गाः स्थानस	full full	
2. Fix.Cat.Uin	Normal	nom	none	nane	none	none	nonn	nom	acmi	ham	full	
R. Oppos Poli	Normal	DOUG	UGUÇ	none	none	none	dont	HOTE	nom	TOTAL	full 5-11	
R. Dors.int.1 R. Abd.Pol.Br.	Normal Normal	nomi nomi	none none	nave evau	none none	none none	राधारम् १९०१सर	TOTAL TOTAL	nonn Ronn	nam nkum	full full	
R. Cer Para C5	Normal	HOTTH	none	none	POUE	none	HOLDS:	nom	попп	nam	fulf	
R. Cer Pana C6	Normal	nom	none	uane	0000	hone	mon	ricetti	mon	norm rom	full full	
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R. Brachioredi	Normal Normal	norm Inc	none none	970h	1+	none none	AOM1 AOM1	norm	UCUII UCUII	nom	fuit fuit	
L. Deltold L. Bloeps Brac	Normal	inc	TODE	ή¢ña	17	MULTE	dom	riorni	ווייסרו	COLLEG	ful)	
L. Ext.Car R.L.	Normal	गदामा	none	none		(NODE)	aem	RECTI	nom	NOM	full 4.0	
L. Triceps L. Ext.Ind.Pro	Normal Normal	nonn nonn	enon enon	none none	none none	HONE Bridit	स्थात सावार	nom nom	nomi nomi	nom	full full	
_ Pronetor Te	Nome	попп	попе	agpa	FIORE	попе	TOTTO	nom	nom	nom	fuD	
Flx.Cer.Uln	Normal	រាជាកា	попр	none	ग्यार	none	nont	PORT	UOIIII	nom nom	full full	
Oppon.Polii Dors.int.1	Normal Normal	nom:	none enune	none none	THORNE:	none none	nomi nomi	nom: nom:	TOTTI	nom	tun	
Abd.Pof.Br.	Normal	DOM:	enon	COUR	ROME	none	TOTAL	ROOM	norm	nom	full	
Cer Para C8 Cer Para C5	Normal Normal	ine Inc	nons	ndne nons	7+ 1+	none enon	USEU USEU	norm porm	nom nom	rioren Corni	fuil fuil	
Cer Para T1	Nomial	nonn	none	UÓU-	none	none	norm	DOM	ROTTI	ПОРТИ	fult	
. Cer Para C7	Normal	nom	none	none	none	uone	eom.		nom	nom	fieli fieli	
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I phone:	edacted	 01/11/12 Olomo	#27051P79D
S.S. No.		 COUNT	H LUCIPASIO

Summary/Interpretation:

- 1. ABNORMAL EMG STUDY
- 2. ELECTRODIAGNOSTIC EVIDENCE (EDX) SUGGESTIVE OF LEFT CERVICAL RADICULOPATHY MOST CONSISTENT WITH C5-6 LEVELS
- 3. NO EDX OF RIGHT CERVICAL RADICULOPATHY
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- 6. NO EDX OF BILATERAL CARPAL TUNNEL SYNDROME
- 7. NO EDX OF BILATERAL BRACHIAL PLEXOPATHY
- 8. PATIENT WILL FOLLOW UP IN 2-3 WEEKS

THOMAS CARUSO, D.O. JEFF S. PIERCE, D.O.

17ch1216704875

(1500)	STATE FARM INSURANCE
(1500)	P.O. BOX 661023 DALLAS TX 75266 J
HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05	DALLIAS IX /3200
PICA	PICA T
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP (Medicare #)	FECA OTHER 18. INSURED'S I.D. NUMBER (For Program in Item 1) BIX LUNG X (ID) 22051P790
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH (
Redacted	FX Redacted
6. PATIENT RELATION Self X Spouse	Chid Other
G B. PATIENT STATUS	
Single M	Anried Other X Time Student Student Student Student Student III. INSURED'S POLICY GROUP OR FECA NUMBER INTERNIT OF PREVIOUS). A. INSURED'S DATE OF BIRTH SEX MM. DO. VY RED CACTED TO: PLACE (State) D. EMPTLOTENT NAME OR PROGRAM NAME C. INSURANCE PLAN NAME OR PROGRAM NAME LOCAL USE D. STATE FARM INSURANCE LOCAL USE LOCAL USE C. INSURANCE PLAN NAME OR PROGRAM NAME LOCAL USE LOCAL USE D. STATE FARM INSURANCE LOCAL USE LOCA
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ģ	urrent or Previous) a. INSURED'S DATE OF BIRTH SEX
a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CI	X No Redacted M FX
b. OTHER INSURED'S DATE OF BIRTH SEX b. AUTO ACCIDENT?	PLACE (State) b. EMPLOYER'S NAME OF SCHOOL NAME
M F X YES	NO MI CINSURANCE PLAN NAME OR PROGRAM NAME
c. EMPLOYER'S NAME OR SCHOOL NAME OTHER ACCIDENT	X NO STATE FARM INSURANCE
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR	1 1
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FOR	YES X NO # yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or to process this claim. I also request payment of government benefits either to myself or to the par	other information necessary payment of medical benefits to the undersigned physician or supplier for
SIGNATURE ON FILE DATE.	01 23 12 SIGNED SIGNATURE ON FILE
	O1 23 12 SIGNED SIGNATURE ON FILE AME OR SIMILAR ILINESS, 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
14. DATE OF CURRENT: (ILINESS (First symptom) OR MM DD YY INJURY (Accident) OR 15. IF PATIENT HAS HAD S GIVE FIRST DATE M9 10 15 11 PREGNANCY (LMP) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.	FROM MM DD YY TO MM DD YY
	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY
THOMAS CARUSO DO 175. NPI 1144333	972 FROM TO
g g	YES X NO 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Un	e) 22. MEDICAJO RESUBMISSION ORIGINAL REF. NO.
1. [722.0]	23. PRIOR AUTHORIZATION NUMBER
2. 1.723.4	R SUPPLIES E. F. G. H. J. J. Z.
24. A. DATE(S) OF SERVICE B. C. D PROCEDURES, SERVICES, C (Explain Unusual Circumstan	R SUPPLIES E. F. G. H. J. J. DIAGNOSIS DIAGNOSIS DAYS IERBOT ID. RENDERING DAYS IERBOT ID. RENDERING DAYS IERBOT ID. PROVIDER ID. #
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6 :	NPI NPI
	ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE (Fox gont claims, see back) \$ 5660 00 \$ 0.00 \$ 5660 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCATION INFO	
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereol.)	
23861 MCNICHOES	2000 TOWN CENTER SUITE 625 SOUTHFIELD MI 48075-1135
SIGNED 01 25 12 1518027606 b.	*1518027606 *
NUCC Instruction Manual available at: www.nucc.org	APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare caim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, consurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance or orgram but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service. 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Scrvices or a civilian employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, hoalth plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the <u>Federal Rogistor</u>, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for med cal care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

<u>ROUTINE USE(S)</u>: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitiement, cialms adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party hability, coordination of benefits, and criminal litigation related to the operation of CHAMPUS.

<u>DISCLOSURES:</u> Voluntary; however, failure to provide information will result in detay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches. MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claimswill be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OWB control number. The valid OWB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer. 7500 Security Boulevard, Baltimore, Waryland 21244-1850. This address is for comments and/or suggestions only DO NOT WALL COMPLETED CLAIM FORMS TO THIS ADDRESS.